MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013596
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB — AMENDED

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED | BY AFFIDAVIT OF | DOCUMENT

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3746

FILED APR 8 1963

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis,Missouri
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 1015 S.Taylor
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY
c. CITY OR TOWN: St.Louis
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 1015 S.Taylor
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First DOROTHY Middle W. Last MEYER

4. DATE OF DEATH: Month 3 Day 30 Year 63

5. SEX: Female

6. COLOR OR RACE: Whi te

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 3-19-1883

9. AGE (last birthday): 80
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): St.Louis,Mo.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Lawrence Kavanaugh

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Geo.W.Meyer (decd)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of servi: no

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Charles Witt 6847 Manchester

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Failure — INTERVAL BETWEEN ONSET AND DEATH: Sudden
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arterio Sclerotic Heart
DUE TO (c): Disease 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 5/17/62 to 3/30/63 and last saw her ~~him~~ alive on 3/23/63
Death occurred at 6:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Malcolm B Bawell M.D.

22b. ADDRESS: 4660 Maryland

22c. DATE SIGNED: 3/30/63

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Apr 2-1963

23c. NAME OF CEMETERY OR CREMATORY: Calvary

23d. LOCATION (City, town, or county) (State): St Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS: Arthur J. Donnelly 3840 Lindell

25. DATE RECD. BY LOCAL REG.: APR 1 1963

26. REGISTRAR'S SIGNATURE: Roan Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Frances Williamson

Licensed Embalmer No. 3565

P. O. Address 3840 Lindell

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.